

**Statement of Professor Thomas L. Greaney**

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and Insurance**

**Committee on Commerce, Science & Transportation  
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**on**

**“Competition in the Health Care Marketplace”**

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Chairman Pryor, Ranking Member Wicker and distinguished Senators: Thank you for your invitation to participate in this important discussion of the state of competition in health care markets. I regret that I was unable to accept your invitation to testify in person, and I greatly appreciate the opportunity to submit my statement in written form.

By way of introduction, I hold the Chester A. Myers Chair and am Director of the Center for Health Law Studies at Saint Louis University School of Law. Before entering academia, I served as the Assistant Chief in the Antitrust Division of the U.S. Department of Justice in the section responsible for health law matters. I am co-author of the leading casebook in health law, a treatise on health law, and numerous articles involving antitrust law, regulation, and competition in health care sector.

I will first review the federal antitrust enforcement record regarding hospitals, physicians and health insurers and analyze the resulting state of competition in these markets. I will then offer a few thoughts on some future directions for the FTC.

### **Health Care Reform and the FTC**

Perhaps more than at any time since the early 1980s, the FTC is positioned to play a leading role in ensuring that the American consumer receives the full benefit of competition in health care markets. The circumstances giving rise to this opportunity are a two-sided coin: (1) the sorry state of competition in provider and payor markets today and (2) the possibility of a major overhaul of health insurance under reform proposals.

It is important to note that *all* reform proposals currently being discussed in Congress rely on competition as the primary vehicle for controlling cost and ensuring high quality and innovation. It is hoped that competition among private insurers (perhaps augmented by a public plan option) will drive hospitals, physicians, pharmaceutical companies and device manufacturers to offer their goods and services at reasonable prices and will reduce excessive and wasteful expenditures. Importantly, reform advocates presuppose that the lever of insurance rivalry will spur provider competition.

Often overlooked is the fact that public health care financing programs also rely heavily on competition. For example, over 64 percent of Medicaid entities receive their services from managed care entities that compete to provide services under state plans. Over 22 percent of Medicare beneficiaries are members of Medicare Advantage plans—private plans that compete for the business of seniors. (Notably, the competitive mechanisms underlying this program can be greatly improved upon so that truly rivalrous bidding, and not subsidies, drive the plans).

### **Recent History: Dubious Court Decisions and Lax Antitrust Enforcement**

Unfortunately, there is a lot of work to do. The competitive structure and performance of provider markets is less than robust. In my view, the federal antitrust enforcement agencies (the FTC and Antitrust Division of the Department of Justice) bear some, though certainly not all, of the responsibility for this state of affairs.<sup>1</sup> I will first discuss the interplay of antitrust enforcement in three important segments of the health care industry: hospitals, physicians and insurance. In each case, antitrust enforcement

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<sup>1</sup> My testimony today does not address the FTC's efforts to promote competition in the pharmaceutical industry, which, by bringing landmark litigation and focusing Congressional attention on the reverse payment issue, ranks among the most significant events in all of antitrust law's history.

has come up short. Coupled with several very questionable decisions from the courts and regulations inhibiting competition, this enforcement failure has left us with the worst of both worlds: concentrated hospital and specialty markets that are resistant to competitive pressures and fragmented delivery systems which fail to integrate practitioners and hospitals to provide seamless, high quality care.

### *Hospitals*

Following seven consecutive defeats by the FTC and DOJ in challenges to hospital mergers (plus one by the Attorney General of California), extraordinary consolidation occurred in hospital and insurance markets. Emboldened by the results in those cases and by the government's ensuing reluctance to challenge mergers in court, concentration grew significantly in almost all sectors of health care delivery and payment. Hundreds of hospital mergers occurred in the 1990s. Meanwhile, not a single case challenging these mergers was brought by the government between 1997 and 2004.

The results of inaction are striking. By 2003 ninety-three percent of the nation's population lived in concentrated hospital markets. And the American consumer bore the brunt of the predictable outcome: hospital consolidation in the 1990s raised overall inpatient prices by at least five percent and by forty percent or more when merging hospitals were closely located.<sup>2</sup> Other, more subtle, results also ensued. Besides price increases owing to enhanced bargaining power, growth in hospital costs appear to have been driven by strategic decisions that take advantage of what economists call market imperfections. By some accounts, the "medical arms race" has resurfaced. Hospitals have undertaken significant expansions in high-margin services and have accelerated

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<sup>2</sup> Robert Wood Johnson Foundation, The Synthesis Project, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care (Feb. 2006).

technology acquisitions, a phenomenon attributable in part to providers' capacity to induce demand following the demise of managed care.

Legal decisions approving mergers of competing acute care hospitals have been roundly criticized. The judicial missteps can be traced to the courts' tendency to oversimplify antitrust analysis by adopting plain vanilla, Chicago School assumptions about markets while failing to incorporate the effects of market imperfections in their analyses.<sup>3</sup> Most of these decisions found extraordinarily large geographic markets for basic acute care hospital services as they ignored the heterogeneity of demand for care and the fact that consumers exhibit different preferences for travel. Other cases refused to recognize supply side heterogeneity, failing to appreciate that mergers of "must have" hospitals may give rise to anticompetitive effects. To right the ship, the FTC has brought two recent hospital merger cases and undertaken retrospective reviews of the outcomes of several hospital mergers. Unfortunately, developing legal precedent takes time and effort and mergers may be attractive to the hospital industry during a period of legal uncertainty and regulatory change. An important priority for the FTC therefore should be to undertake close scrutiny of *all* horizontal consolidations by hospitals-- including joint ventures involving physician-controlled specialty hospitals and outpatient facilities, none of which have been challenged to date.

### *Physicians*

Turning to physician markets, I'm sorry to report the antitrust enforcement record is equally bleak. Despite having challenged or written advisory opinions over the last

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<sup>3</sup> See Thomas L. Greaney, *Chicago's Procrustean Bed: Applying Antitrust in Health Care*, 71 Antitrust L.J.857 (2004). Kenneth L. Danger & H.E. Frech, *Critical Thinking About "Critical Loss" in Antitrust*, 46 Antitrust Bull. 339 (2001); James Langenfeld & Wenqing Li, *Critical Loss in Evaluating Mergers*, 46 Antitrust Bulletin 299 (2001).

three decades in over 75 cases involving cartels of physicians, dentists and other providers attempting to obstruct competition or fix prices, federal antitrust enforcers continue to encounter physician networks that violate the antitrust laws. As recently as last month, the Commission settled charges that a 600-member IPA in California had engaged in collective negotiations of fees since 2001 and had attempted to limit the product offerings of Kaiser Permanente through an unlawful concerted refusal to deal. As I explained in my article, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, the explanation for the persistence of these abuses lies in the failure of the FTC and DOJ to impose strong remedies against what are thinly-disguised price fixing cartels. Instead of issuing “wrist slap” consent orders (referred to by antitrust practitioners as “go forth and sin no more” decrees), the agencies should have imposed sanctions on individuals (especially consultants who cook up these schemes), disgorgement of profits, and perhaps in a few egregious cases, criminal sanctions.

The FTC has bent over backwards attempting to delineate conditions under which physician networks can “clinically integrate” their practices so as to avoid summary condemnation under the antitrust laws. If health reform legislation encourages physicians to establish “medical homes” or accountable health organizations, it is likely that the limits of loose organizational relationships will be further tested. My view is that while the Commission has drawn sensible and doctrinally-sound lines in this area, some physicians will continue test the envelope, adopting the least integrative means to pass antitrust muster. Unless organizations craft meaningful rewards and punishments to assure that members have a collective interest in controlling costs and volume of services, these networks will be just another cover for physicians collectively exercising market

power. I agree with FTC Commissioner Rosch who has urged caution in accepting clinical integration proposals, stating, “the safest and most realistic form of integration that a physician joint venture can undertake is time tested *financial* integration.”<sup>4</sup> Economics and experience teach that having a meaningful stake in a venture is the most effective means of getting joint venture participants to commit to controlling costs—here, counteracting the perverse incentives of fee-for-service payment.

A second area of antitrust concern is physician mergers. Remarkably, the federal agencies have never brought a single antitrust suit involving physician mergers of physician practices (though a handful of state attorneys general have done so). The results of the enforcement deficit here are again a matter of serious concern. Increasingly specialists have merged to form single-specialty groups, which are able to use their market power to negotiate higher reimbursement. And ironically, the kind of consolidation that produces better quality and seamless care--the multi-specialty practice-- has become less prevalent. These disturbing trends are not entirely the fault of antitrust enforcement, as government and private payment systems encourage the wrong kind of consolidation. However, antitrust enforcement might have stemmed the tide in markets where specialists have gained monopoly power.

#### *Health Insurance and PBMs*

While responsibility for antitrust oversight of the insurance industry rests primarily with the Antitrust Division of the Department of Justice, developments in that sector have important ramifications for the health care system. Although there have been

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<sup>4</sup> Commissioner J. Thomas Rosch, “Clinical Integration in Antitrust: Prospects for the Future,” Remarks Before the American Health Lawyers Association, ABA Antitrust Section and ABA Health Law Section, 2007 Antitrust in Health Care Conference, Washington, D.C.(September 17, 2007), available at: <http://www.ftc.gov/speeches/rosch/070917clinic.pdf>.

some 400 insurance mergers over the past decade, only three have met with challenge from the DOJ. In several cases, the Department’s oversight (in both senses of the word) is hard to justify. Although precise data is lacking, there is little dispute that most health insurance markets in the United States are highly concentrated and many are dominated by one or two firms. The results in these markets appear to confirm what economic theory predicts: higher premiums for consumers and high profits for the insurance industry. Summarizing studies indicating that private insurance revenue increased even faster than medical costs, economist John Holahan and Linda Blumberg of the Urban Institute concluded that “insurer market power allowed the firms to not only pass on rising health care costs to purchasers but to also increase profits.”<sup>5</sup> In addition, experience suggests that entry into concentrated insurance markets is far from easy and that we should not expect new competition to arise magically after health reform.

The existence of oligopolies or monopolies in both the provider and insurance sectors creates opportunities for anti-competitive mischief. As mentioned earlier, dominant hospital systems and dominant single-specialty physician groups have been able to charge higher prices which in turn result in higher insurance premiums (and, as some studies show, increased disparities in access to care). But what happens when dominant insurers face dominant providers—what economists call bilateral monopoly? The outcome depends on the strategic interactions of the parties. For example, in the case of the now notorious situation Partners Health Care and Blue Cross of Massachusetts, the parties reached a mutually beneficial understanding (a “market covenant”) to maintain high premiums and high hospital charges. More generally it appears the dynamics of

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<sup>5</sup> John Holahan & Linda Blumberg, Urban Institute Health Policy Center, *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Care Reform?* at 3 (available at [http://www.urban.org/health\\_policy/url.cfm?ID=411762](http://www.urban.org/health_policy/url.cfm?ID=411762)).

bargaining may often result in higher prices for consumers. As Holahan and Blumberg summarized industry tendencies:

Dominant insurers do not seem to use their market power to drive hard bargains with providers, [while] small insurers do not aggressively compete over price. Rather, rising premiums and increased profitability of nondominant firms provide indirect evidence of shadow pricing by smaller insurers; that is, smaller insurers do not seem to compete on premiums to gain market share but rather seem to follow the pricing of the dominant insurer.<sup>6</sup>

The PBM market has also seen rapid consolidation, in part due to lax antitrust enforcement. With over a dozen PBM mergers in the past eight years (and another one currently pending), the three major PBMs control approximately 80% of the national market. Two of the largest PBM mergers – Caremark’s acquisition of AdvancePCS and CVS’s acquisition of Caremark – were approved without a significant investigation. Since the Caremark/AdvancePCS merger was consummated, national full service PBM market concentration has become more problematic as the largest organizations have grown significantly. Cases brought by state attorneys general involving deceptive conduct and other abuses by PBMs and recent allegations now being investigated by the FTC that CVS Caremark improperly shared patient information with the company’s retail side to steer customers to CVS stores<sup>7</sup> illustrate risks that intermediaries with market power can pose.

### *Summary*

It has become commonplace for experts to observe that “our healthcare system is broken.” The foregoing analysis adds an extra measure of gloom, suggesting that the nation’s competitive infrastructure-- provider and payor markets-- is not well designed to

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<sup>6</sup> Id.

<sup>7</sup> Dinah Wisenberg Brin, *FTC OKs Final CVS Caremark Order; Refers Pharmacists’ Concerns*, Wall St. J. (June 23, 2009).

produce cost savings if reform proposals simply turn over the job to the private market. Though not the subject of today's hearing, in my view this quandary lends strong support to the idea of having a public plan option to nudge private insurers toward more vigorous competition and to serve as a backstop where markets fail.<sup>8</sup> At the same time, we have gained enough experience in the many markets in which competition works reasonably well and provider markets are function well to have some cause for hope. The following comments offer some ideas for ensuring more vigorous competition by increasing antitrust law vigilance as reform goes forward.

### **What Can the FTC Do?**

Antitrust enforcement offers no panacea for the problems sketched above. First, myriad market imperfections complicate the workings of competition in health care markets. While enforcers should sometimes adjust economic analysis in antitrust cases account for imperfect information, agency relationships, and distortions caused by insurance, antitrust law cannot itself correct these problems. Secondly, it should be remembered that antitrust law does not interfere with legally acquired monopolies or oligopolies. Thus, to a considerable extent, the horse is out of the barn as far as the consolidation of physician, hospital and insurance markets that has already occurred. However, the FTC and the Department of Justice can employ the tools of the antitrust statutes and the FTC Act to prevent *abuses* of those dominant positions. Further the agencies can actively target conduct that interferes with entry by new market participants and can prevent private parties imposing obstacles to the emergence of new “disruptive”

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<sup>8</sup> My argument that a public plan would improve competitive performance of health care markets is found in *Paying Attention to Competition: Payors, Providers and the Public Plan*, Health Reform Watch <http://www.healthreformwatch.com/2009/06/21/2493/>.

technologies that can help make markets more competitive. Finally, the FTC can lead the way through its administrative proceedings and can serve as a “competition think tank” to add needed research and information for use by legislators and courts.

In closing, let me offer a few specific ways to improve FTC oversight of competition in health care:

- *The FTC Should Carefully Monitor Markets Dominated by Single Providers.* The risk of exclusionary conduct by hospitals and single-specialty groups are significant where contracts with payors permit them to exclude or cripple rivals. No cases have been brought in nearly a decade challenging dominant providers or insurers; indeed the Department of Justice did not bring a single monopolization suit in eight years challenging unilateral conduct or vertical conduct.
- *The FTC Can Carry a Bigger Stick.* There are a number of steps the FTC can take to improve the effectiveness of its oversight of the health care sector. For example, antitrust has a remedy that, in the words of Professor Einer Elhauge is “legally available, enormously powerful, but seldom used”<sup>9</sup> That remedy—disgorgement-- allows for recovery of illicit profits and would go a long way to discouraging the repeated violations of the law as seen in the physician cartels discussed earlier. In other cases the FTC could insist on breaking up networks or joint ventures that engage in cartelizing or exclusionary conduct instead of simply admonishing the parties not to repeat their conduct. Finally, as Chairman Leibowitz and Commissioner Rosch have suggested, Section 5 of the FTC Act can enable the FTC to fill gaps in the antitrust laws and reach conduct that harms

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<sup>9</sup> Einer Elhauge, *Disgorgement as an Antitrust Remedy*, 76 Antitrust L.J. 501 (2009).

competition but for various technical reasons fall outside the scope of antitrust laws.

- *The FTC Can Be Both an Advocate and Think Tank in Support of Governmental Competition Initiatives.* Many of the most important obstacles to competition are not subject to antitrust challenge because they emanate from government policies. For example, the antikickback and Stark law rules inhibit procompetitive vertical integration between physicians and hospitals; certificate of need law can inhibit deconcentrative entry by new hospitals and other facilities; and Medicare and Medicaid managed care programs may not sufficiently encourage efficient competitive bidding and contracting. The FTC and Department of Justice can and should provide competition advocacy and research in support of reducing barriers to competition and improving competitive bidding.
- *The FTC Can Supply Essential Research.* Some of the thorniest questions in applying antitrust to health care markets have yet to be addressed. For example, how should courts evaluate the efficiencies associated with scale in performing procedures? What are the competitive implications of provider-induced demand? If health care reform proposals create new markets mediated by an exchange, what are the boundaries of these markets and what are the implications of governmental supervision? The FTC's economic and policy units are uniquely well suited to provide expertise that will help shape the debate on these subjects.
- *The FTC Can Supply Guidance in Interpreting the Impact of Health Reform on Antitrust Law.* Reform seems likely to change relationships between insurers and

consumers and will almost certainly increase the role of government. These changes will cause uncertainty with respect to a host of antitrust topics, e.g. the State Action Doctrine, implied repeal of antitrust law, and market definition, to name a few. History teaches that in these circumstances, legal uncertainty can deter efficiency-enhancing cooperation and impose unnecessary costs on parties seeking to redefine their relationships. The FTC has a variety of tools at its disposal, ranging from informal guidance to policy statements to administrative rule-making, that may be deployed to combat uncertainty and deter violations of the law.

In closing, it is worth remembering the words of President Woodrow Wilson who envisioned a new regulatory agency that would be “an indispensable instrument of information and publicity, a clearing house for the facts by which both the public mind and the managers of great business undertakings should be guided and as an instrumentality for doing justice to business where the processes of the courts or the natural forces of correction are inadequate.” The outstanding new leadership at the FTC appears eminently qualified, and one hopes, willing, to fulfill that vision.

[For the Committee’s convenience, I am attaching two of my recent publications that give a fuller account of the arguments made in this statement, *Competition Policy and Organizational Fragmentation in Health Care* and *Thirty Years of Solicitude: Physician Cartels and Antitrust*. These publications may be downloaded at: <http://ssrn.com/author=138959> ]